

**Montana Marijuana Program
CHANGE REQUEST FORM**

Registered cardholders (patients) and providers/MIPPS must use this form to submit any information changes to the department.

REVIEW THE CHECKLIST BELOW BEFORE SUBMITTING THIS FORM TO THE DEPARTMENT

- Mail this completed form to DPHHS/MMP, PO Box 202953, Helena, MT 59620-2953
- There is no fee for submitting a change request
- More than one change can be made on a single form
- If a patient is adding or changing provider/MIPP, the patient **and** new provider/MIPP must sign form.
- Provider information will only be changed if the *provider* submits a change request form. Provider information will not be changed if the change request form is for a registered cardholder.

☐ Add Provider ☐ Change Provider ☐ Remove Provider ☐ Remove Patient

☐ Name Change (requires legal documentation) ☐ Street address Change

☐ Mailing address change ☐ Registered premises (grow location) address change*

☐ Other, Specify _____

*If you will be cultivating and/or manufacturing marijuana at an address that is rented or leased, you must include a LANDLORD PERMISSION FORM with this change request.

REGISTERED CARDHOLDER (PATIENT) INFORMATION

COMPLETE THIS SECTION IF THE REGISTERED CARDHOLDER IS CHANGING PERSONAL INFORMATION OR
ADDING OR REMOVING A PROVIDER

Current card number: _____ Expiration date: _____

Legal Name (Last): _____ (First): _____ MI: _____

Social Security Number: _____ Phone Number: _____

Montana Driver's License number or State of Montana issued ID number: _____

Mailing Address: _____ City: _____ Zip Code: _____

Street Address: _____ City: _____ Zip Code: _____

Registered Premises Address: _____

City: _____ Zip Code: _____

Signature of registered cardholder

Date

PROVIDER/MIPP INFORMATION

COMPLETE THIS SECTION IF THE REGISTERED CARDHOLDER IS CHANGING OR
ADDING PROVIDER/MIPP OR PROVIDER/MIPP IS CHANGING PERSONAL
INFORMATION OR REMOVING A PATIENT

Current Provider/MIPP ID: _____ Date of Birth: _____

Legal Name (Last): _____ (First): _____ MI: _____

Social Security Number: _____ Phone Number: _____

Montana Driver's License number or State of Montana issued ID number: _____

Mailing Address: _____ City: _____ Zip Code: _____

Street Address: _____ City: _____ Zip Code: _____

Registered Premises Address: _____

City: _____ Zip Code: _____

Signature of provider/MIPP

Date

If registered cardholder (patient) is requesting a provider/MIPP that is not a currently registered with the department, the department will send the individual a provider/MIPP application packet.